Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: James Tyler, D.O. P.O. Box 743125 Dallas, TX 75374	MFDR Tracking #: M4-07-6401-01 DWC Claim #: [redacted] Injured Employee: [redacted] Date of Injury: [redacted]
Respondent Name and Box #: Texas Mutual Insurance Co. Rep. Box #: 54	Employer Name: [redacted] Insurance Carrier #: [redacted]

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary:

- **No Private Right of Action**: Financial Disclosure statute includes exclusive remedies that do not include a private right of action.
- **No Violation of Financial Disclosure Requirements**: Physicians had no ownership interest in, were not employed by, and received no compensation from DII. Physicians referred injured workers to DII for functional capacity examinations and other testing. Physicians submitted bills on behalf of DII pursuant to the medical fee guidelines and remitted the full amount of the charges to DII as reimbursement for services rendered.
- **No Failure to Supervise**: Referring physicians supervised the DII technicians. (Refer to the attached Affidavit) Other than generalized allegations, Texas Mutual has not identified specific instances where technicians were not supervised.
- **Insufficient Notice**: Texas Mutual has not provided sufficient explanation of any violation and has not identified specific instances were FCE's were billed in excess of medical fee guidelines.
- **FCE's Properly Billed**: All charges for FCE's were made pursuant to medical fee guidelines.

Principal Documentation:

1. DWC 60 package
2. Amount Sought: $284.08
3. CMS 1500s
4. EOBs
5. Affidavit signed by James Tyler, O.D.
6. FCE Report

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary:

- **Services are not payable because financial disclosures as required by DWC Rules have not been made.** Southwest Medical's and Diagnostic Imaging's health care practitioners, including its doctors, have undisclosed compensation arrangements. Division Rule 180.24 provides that a doctor must disclose any arrangement involving any remuneration between a health care practitioner (or a member of a health care practitioner's immediate family) and a health care provider, including a direct or indirect ownership or investment interest in a health car provider; or a direct or indirect compensation arrangement between the health care practitioner, the health care provider who employs the referring health care practitioner, or an immediate family member of the health care practitioner and a health care provider. Southwest Medical and Diagnostic Imaging are health care providers sharing common ownership and facilities... Doctors who have contracts or other financial relationship with Diagnostic Imaging and/or Southwest Medical have not disclosed their financial interests in these entities and so are not entitled to any amounts paid for services while they are non-compliant with DWC Rule 180.24...
- **FCE times have not been properly calculated and billed in accordance with fee guidelines.** Diagnostic Imaging has acknowledged in prior communications that the actual time spent in *performing the test* is less than the time billed. Diagnostic Imaging admitted that the time billed includes extraneous charges such as preparing reports and the time a patient spends in the waiting room filling out paperwork. Under the Division's Fee Guideline, FCEs *are Division-specific services*. Rule 134.202(a)(4) provides that, for Division-specific services: "Specific provisions contained in the Texas Workers' Compensation Act (the Act), or Texas Workers' Compensation Commission (Commission) rules, including this rule, shall take precedence over *any conflicting provision* adopted by or utilized by CMS in administering the Medicare program." The Rule states what an FCE entails: (1) a physical examination and neurological evaluation, (2) a physical capacity evaluation of the injured area, and (3) functional abilities tests. **In any event, Texas Mutual has determined the services to be not otherwise payable in full...**
- ***Services requiring supervision were not performed under the supervision of a doctor for the purposes of billing these services.*** DWC Rule require that the health care provider must submit his or her own bill, unless the health care was provided by an unlicensed individual *under the direct supervision* of a licensed health care provider, in which case the supervising health care provider must submit the bill; and that a medical bill must be in the name of the licensed health care provider who rendered the services or provided *direct supervision* of an unlicensed individual who provided the health care. ...FCEs were performed by non-licensed technicians employed by Diagnostic Imaging and then billed under Dr. Karl Erwin's license (Box 31 of the HCFA-1500). Diagnostic Imaging has stated that, as a matter of fact and law, Diagnostic Imaging technicians are under the "direct supervision" of the referring doctor, who is not necessarily Dr. Erwin. Consequently, Texas Mutual cannot determined from the billing, who supervised the unlicensed individual.
- ***Diagnostic Imaging had no authority to submit a bill on behalf of the referring doctor.*** Regarding bills for the psychological testing and FCEs performed by a technician, under the DWC billing rules... Diagnostic Imaging had no authority to submit a bill on behalf of the referring doctor. The referring doctor must submit his or her own bill.
- ***Services are billed in excess of the usual and customary rate.***

Principal Documentation:

1. Response to DWC 60
2. Position Statement taken from the detailed response dated March 5, 2007 and received by the Division on June 14, 2007.

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
11/13/06	CPT Code 97750-FC	B7, W1, W4, 790, 891, 896	1 - 11	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code (TLC) 413.011 (a) – (d) and (f)
28 Texas Administrative Code (TAC) 133.20 (d)(3); 134.202(a)(5), (b), (c)(5), (d), and (e)(4); and 180.24(a)(1), (2)(B), (b)(1), (c) set out the reimbursement guidelines.

1. Medical Fee Dispute Resolution (MFDR) received the request for dispute resolution on May 25, 2007.
2. These services were denied/reduced by the Respondent with reason code "B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service"; "W1 – Workers Compensation State Fee Schedule Adjustment"; "W4 – No additional reimbursement allowed after review of appeal/reconsideration"; "790 – This charge was reimbursed in

accordance to the Texas Medical Fee Guideline"; "891 – The insurance company is reducing or denying payment after reconsideration" and "896 – Statutory/regulatory violation." The insurance carrier also included, on the reconsideration EOB, this statement: "The referring doctor must submit his or her own bill. Per Rule 180.24, financial disclosure not met. Direct Supervision by licensed physician/health care provider lacking. Number of units billed exceeds number of units performed. See also explanation of EOB dated 12/07/06 previously sent. See detailed response dated 03/05/2007 previously sent."

3. **Financial Disclosure Issue:** The Requestor, James Tyler, D.O., submitted an affidavit that stated, in pertinent part: "I have no financial relationship with DII other than the bill for the FCE is submitted by me on behalf of the DII technician and once payment is made **I reimburse DII for its services** (emphasis added)." The Requestor also stated that he referred the injured employee to DII for the FCE. This evidence supports that the Requestor did have a direct or indirect compensation arrangement with DII as specified in 28 TAC 180.24 (a)(1) and (2)(B). However, the Division has no record of the Requestor filing the required financial disclosure information as required by 28 TAC 180.24 (b)(1). The Requestor provided a "Request For Reconsideration" billing form that it submitted to the Respondent for this FCE in which it specified DII as the "Name And Address Of Facility Where Services Were Rendered" and the "Physician's, Supplier's Billing Name..." In addition, the Requestor's Affidavit states that he has "...authorized DII to act as my billing agent for purposes of billing and collecting payment for the FCE." Therefore, the Requestor has not complied with the financial interest disclosure requirements and 28 TAC 180.24 (c) prohibits payment for the FCE involved in this dispute. Note: A financial interest disclosure requirement has not been established by the Respondent based upon the Respondent's assertions concerning Southwest Medical Examination Services, Inc. ("SME") because it has not provided sufficient evidence to show that SME is a health care provider or that SME provided the services involved in this dispute.

4. **Supervision Issue:** The submitted Affidavit signed by the Requestor contains statements that do not satisfy the required billing and payment policies of the Centers for Medicare and Medicaid Services ("CMS") as required by 28 TAC 134.202 (a)(5) and (b). The Requestor states, in pertinent part: "...I referred [the injured employee] to Diagnostic Imaging Institute ("DII") for a Functional Capacity Evaluation ("FCE")." However, he then asserts that; "The FCE was conducted under my direction and supervision..." The FCE report submitted by the Requestor listed DII and its address at the bottom of each page, stated that the injured employee was referred to DII for the FCE, and stated the purpose of the FCE. The FCE Report is signed by Dr. Karl Erwin, and DII's legal counsel has confirmed to the Division that Dr. Erwin is employed by DII; legal counsel for DII has also confirmed that the technicians that performed the FCEs billed by DII are employed by DII and not the Requestor who referred the requested FCE to DII. Therefore, the greater weight of the evidence supports the factual finding that the Requestor referred to DII to perform the FCE rather than the FCE being performed by auxiliary personnel employed by or under contract with the Requestor. Therefore, the Requestor cannot rely upon the "Incident to Physician's Professional Services" provisions of the Centers for Medicare and Medicaid Services Benefit Policy Manual, Chapter 15, Part 60.1 subpart B, because the FCE services here were not "...furnished as an integral, although incidental, part of the physician's personal professional services..." and the DII technicians were not "...acting under the supervision" of the Requestor because they were employed by DII and acting pursuant to a referral made by the Requestor to DII. Legal counsel for DII has confirmed to the Division that the DII technicians performing DII FCEs were not licensed and that neither Dr. Erwin nor any DII employed or contracted physician was in the suite of offices where the DII FCEs were provided. Therefore, the Requestor has not provided sufficient information to demonstrate that DII met CMS requirements for the personnel rendering the FCE services as noted in 42 Code of Federal Regulations §§485.58 (d)(2), (4), and (6) and 484.4 and/or for the requirements of the Centers for Medicare and Medicaid Services Benefit Policy Manual, Chapter 15, Part 230.4 subpart B.

5. **Billing Agent Issue:** 28 TAC 133.20 (d)(3) permits an agent of a health care provider to submit a bill to the insurance carrier for payment. The Requestor, in his Affidavit, indicates that he has authorized DII to bill for his services. However, as noted above, the services were provided by DII and not the Requestor. Therefore, DII could not bill for the FCE involved in this dispute as the billing agent of the Requestor.

6. **Usual and customary charge Issue:** Administrative billing services are part of the usual and customary charge of a health care provider, like DII, and, as such, should be included when determining DII's usual and customary charge. The Respondent has not submitted sufficient evidence in this dispute that supports that DII did not bill its "usual and customary charge." This allegation of the Respondent has not been substantiated.

7. Box 33 of the CMS-1500 reflects Diagnostic Imaging, Inc. as the billing agent. Box 33 of the CMS-1500 indicates the physician's/supplier's billing name, address, zip code and phone number.

8. According to 28 TAC 134.202 (e)(4) - Functional Capacity Evaluations (FCEs), a maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the commission shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using the "Physical performance test or measurement..." CPT code with modifier "FC." FCEs shall be reimbursed in accordance with subsection (c)(1). Reimbursement shall be for up to a maximum of four hours for the initial test or for a commission ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. **FCEs shall include the following elements:** (A) A physical examination and neurological evaluation, which include the following: (i)

appearance (observational and palpation), (ii) flexibility of the extremity joint or spinal region (usually observational), (iii) posture and deformities, (iv) vascular integrity, (v) neurological tests to detect sensory deficit, (vi) myotomal strength to detect gross motor deficit and (vii) reflexes to detect neurological reflex symmetry. (B) A physical capacity evaluation of the injured area, which includes the following: (i) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and (ii) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative data base. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes. (C) Functional abilities tests, which include the following: (i) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing); (ii) hand function tests which measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices; (iii) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and (iv) static positional tolerance (observational determination of tolerance for sitting or standing). Review of the FCE report reveals the elements of the FCE not met were appearance (observational and palpation), flexibility, vascular integrity, neurological tests to detect sensory deficit, myotomal strength, reflexes, range of motion of the injured joint or region, and submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill.

9. 28 TAC 134.202 (d) establishes that "reimbursement shall be the least of the (1) MAR (maximum allowable reimbursement) amount as established by this Rule or, (2) the health care providers' usual and customary charge or (3) the health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service." CPT Code 97750-FC is a Division specific code and is paid in 15 minute increments per 28 TAC 134.202 (c)(5). Review of the FCE report revealed that an FCE was performed, starting at 9 am and ending at 11am, indicating a 2 hour FCE.
10. In summary, the Division has found payment for the FCE is not authorized for the reasons specified above.
11. Part VIII below specifies the right of either party to appeal this decision to an evidentiary, adjudicatory hearing. Therefore, the request for such a hearing by the Respondent is not addressed.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

- Texas Labor Code 413.011(a) – (d) and (f);
- 42 Code of Federal Regulations 485.58(d)(2), (4), and (6);
- 42 Code of Federal Regulations 484.4;
- 28 TAC 180.24 (a)(1), (2)(B), (b)(1), (c);
- 28 TAC 133.20 (d)(3);
- 28 TAC 133.260 (b);
- 28 TAC 134.202 (a)(5), (b), (c)(5), (d), and (e)(4);
- Texas Government Code, Chapter 2001, Subchapter G; and
- Centers for Medicare and Medicaid Services Benefit Policy Manual, Chapter 15, Part 60.1 subpart B and Part 230.4 subpart B

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC §413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

Marguerite Foster	Marguerite Foster	May 29 , 2008
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under TLC §413.0311, your appeal will be handled by a Division hearing under Title 28 TAC Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under TLC §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.